



IDAHO SOUND BEGINNINGS REFERRAL FOR AUDIOLOGIC - RESCREENING or DIAGNOSTIC EVALUATION -

HOSPITAL: _____ Today's Date: _____

BABY'S NAME: _____ (M) (F) DATE OF BIRTH: _____

Mother's Last Name (if different from baby's): _____

• BABY'S HOSPITAL MEDICAL RECORD #:

• RESULTS: First Screen - R _____ L _____ Screening Method: ABR _____ OAE _____
Second/Re-Screen - R _____ L _____ Date of Re-Screen: _____

BABY'S PRIMARY PHYSICIAN: _____

• PARENT/GUARDIAN:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

• AUDIOLOGIST/CLINIC REFERRED TO:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

DATE OF DIAGNOSTIC EVAL. (if known): _____

RISK INDICATORS:

- ___ Family History of Permanent Childhood Hearing Loss
- ___ Gestational Age < 32 weeks
- ___ Syndrome Associated with HL
- ___ Low Birthweight (<3.3 lbs.)
- ___ Congenital Infection (e.g. T-O-R-C-H)
- ___ Postnatal Infection (e.g. Meningitis)
- ___ Hyperbilirubinemia (requiring transfusion)
- ___ Craniofacial Abnormalities
- ___ Low Apgar Scores (< 7/5)
- ___ Mechanical Ventilation > 10 days
- ___ Ototoxic Medications
- ___ Other _____

- For information on **financial assistance** for the audiologic evaluation, please call the **Idaho CareLine** at '2-1-1' or - (800) 926-2588 (voice) - (208) 332-7205 (tty).

I hereby give permission to the staff of the above-named hospital to release **medical** information necessary to complete an audiological evaluation for my child to the above-named audiologist/clinic (or the audiologist of my choice) and physician. I also give permission to the above named hospital and audiologist/clinic to share information about the results of the hearing screening and diagnostic audiologic evaluations with the staff at my child's birth hospital, the above-named physician, the Idaho Infant-Toddler Program, the Idaho Early Hearing Detection and Intervention Project (EHDI), Idaho School for the Deaf and Blind, and Idaho Hands & Voices. I understand that the information will be used to ensure that appropriate and timely medical, educational, and audiologic services are made available to my child. The hospital staff has informed me of my baby's hearing screen results and of the need for either a re-screen or further diagnostic audiological evaluation.

I have had the opportunity to read this hospital's Notice of Privacy Practices. I understand that this information will not be shared with unauthorized individuals. This authorization expires 36 months from the date signed.

• PARENT/GUARDIAN: _____ Date: _____
(Signature required - obtain signature at initial refer result!)

TO THE SCREENER: Please return this form within 10 days* of referral date to:

MAIL: Idaho Sound Beginnings (EHDI) Project (208) 334-0983
450 W State St. Floor-5 / PO Box 83720
Boise, ID 83720-0036 or FAX: (208) 332-7330

DISTRIBUTION: **White**-Audiologist, **Gold**-EHDI Project, **Yellow**-Physician, **Pink**-Hospital, **Green**-Parent(s)

*(If an Outpatient Re-Screen is scheduled, and the baby does not return within 30 days, please distribute the signed referral as listed above.)